DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

September 25, 2013

Julie Weinberg
PO Box 2348
Santa Fe, NM 87504-2348

Dear Ms. Weinberg:

This letter is to inform you that New Mexico's request to amend the authorities for its Title XIX section 1115 demonstration, the *New Mexico State Coverage Insurance Demonstration* (number 11-W-00247/6) has been approved in order to not disrupt the coverage currently afforded in New Mexico. The state will receive federal financial participation at the state's regular federal medical assistance percentage (FMAP) for demonstration expenditures from October 1, 2013 through December 31, 2013.

The demonstration will include the parents' population formerly funded with funding under title XXI. Pursuant to the changes in authority resulting from the Children's Health Insurance Program Reauthorization Act of 2010 (CHIPRA), as of October 1, 2013, New Mexico will cease to claim Title XXI federal match for the Parents population, and will begin claiming Title XIX federal financial participation match. For these parents, this change from Title XXI funding to Title XIX funding should be a seamless transition.

In addition, as agreed in discussions with the state, in light of the coverage options that will be available beginning January 1, 2014 to residents of New Mexico under the Medicaid state plan and through the Marketplace, we will continue to work with you on a transition plan to facilitate a seamless transfer of coverage for those currently enrolled in the demonstration.

Our approval of this demonstration is subject to the limitations specified in the enclosed approved expenditure and waiver authorities, and special terms and conditions (STCs). These documents specify the agreement between the State of New Mexico Department of Human Services and the Centers for Medicare and Medicaid Services (CMS). The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as granted expenditure authority or waived. All requirements of the Medicaid programs as expressed in law, regulation, and policy statement not expressly identified as waived or made not applicable in the enclosed authorities shall apply.

This approval is also conditioned upon continued compliance with the enclosed STCs which set forth in detail the nature, character, and extent of federal involvement in this demonstration and the state's obligations to CMS, including an evaluation of this demonstration, during the term of the approval period. This award letter is subject to our receipt of your written acceptance of the award, including the waiver and expenditure authorities and the STCs, within 30 days of the date of this letter.

Your project officer is Kelly Heilman. Kelly is available to answer any questions concerning your section 1115 demonstration, and may be reached by phone at 410-786-1451 or by email at kelly.heilman@cms.hhs.gov. Communications regarding program matters and official correspondence concerning the demonstration should be submitted at the following address:

Kelly Heilman, PhD, MBA
Division of State Demonstrations & Waivers
Center for Medicaid & CHIP Services
Mailstop: S2-01-16
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Official communications regarding program matters should be submitted simultaneously to Mr. Bill Brooks, Associate Regional Administrator in our Dallas Regional Office. Mr. Brooks' contact information is as follows:

Mr. Bill Brooks
Associate Regional Administrator
Centers for Medicare & Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

If you have additional concerns regarding CMS oversight of the demonstration or questions, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at 410-786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Bill Brooks, Dallas Regional Office
Suzette Seng, Dallas Regional Office

Stacey S. Shuman, Dallas Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00247/6**

TITLE: **New Mexico State Coverage Insurance Section 1115 Demonstration**

AWARDEE: **State of New Mexico Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this Demonstration, shall be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable the State to operate its section 1115 Medicaid State Coverage Insurance Demonstration.

1. Expenditures for health care related costs for non-pregnant Childless Adults and CHIP Parents ages 19 through 64 years who have family income at or below 200 percent of the Federal Poverty Level (FPL), who are not otherwise eligible under the Medicaid State plan, and who do not have other health benefits coverage.

2. Expenditures for capitation payments for services furnished to the non-pregnant childless adult and the CHIP Parent populations described in Expenditure Authority No. 1 above, even though enrollees do not always have a choice between at least two Managed Care Organizations, as required under section 1932(a)(3) of the Act, and even though the plans do not meet the requirements under section 1903(m)(2)(A)(vi) and section 1932(a)(4) of the Act because they restrict enrollee rights to disenroll within 90 days of enrollment.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration Population beginning January 1, 2010, through September 30, 2014.

Title XIX Requirements Not Applicable to the Demonstration Population:

1. **Reasonable Promptness** **Section 1902(a)(3) and 1902(a)(8)**

To the extent necessary to enable the State to cap enrollment for the Demonstration-Eligible Population in order to remain under the annual budget neutrality limits under the Demonstration.

2. **Amount, Duration and Scope** **Section 1902(a)(10)(B)**

To the extent necessary to enable the State to offer a different benefit package to the Demonstration-Eligible Population that varies in amount, duration, and scope from the benefits offered under the State plan.

3. **Freedom of Choice** **Section 1902(a)(23)**

To the extent necessary to enable the State to restrict freedom of choice of provider.

4. **Retroactive Eligibility** **Section 1902(a)(34)**

To the extent necessary to enable the State to not provide coverage for the Demonstration-Eligible Population for any time prior to the first day of the month following enrollment and receipt of payment by the State.

5. **Eligibility Standards** **Section 1902(a)(17)**

To the extent necessary to enable the State to apply different eligibility methodologies and standards to the Demonstration-Eligible Population than are applied under the State plan.

6. **Methods of Administration: Transportation** **Section 1902(a)(4), insofar as it Incorporates 42 CFR 431.53**

To the extent necessary to enable the State to not assure non-emergency medical transportation to and from providers for the Demonstration-Eligible Population.

7. **Dental, Hearing, and Vision Services** **Section 1902(a)(43)**

To the extent necessary to enable the State to not provide coverage of dental, hearing and vision services to individuals ages 19 and 20 in the Demonstration-Eligible Population.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00247/6**

TITLE: **New Mexico State Coverage Insurance Section 1115 Demonstration**

AWARDEE: **State of New Mexico Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New Mexico's State Coverage Insurance Section 1115(a) Medicaid demonstration extension (hereinafter referred to as "demonstration"). The parties to this agreement are the New Mexico Department of Human Services (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The STCs are effective January 1, 2010 unless otherwise specified. This demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility and Enrollment; Benefits and Cost-Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of Deliverables for the Demonstration Extension Period.

Section 2111(a)(2)(A) of the Social Security Act (the Act), as enacted by Section 112 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), requires that no Title XXI funding can be available for health assistance provided to non-pregnant childless adults after December 31, 2009. Section 2111(a)(3) of the Act provides an opportunity for states with applicable existing CHIP childless adult coverage waivers to apply for new Medicaid demonstrations under special budget neutrality rules, that will allow them to continue coverage for their non-pregnant childless adults. New Mexico exercised this option and submitted an application for a new Medicaid demonstration on September 29, 2009, in order to continue the State Coverage Insurance (SCI) demonstration for childless adults using Title XIX funding.

CHIPRA also changed states' authority to cover parents under a Title XXI program. Specifically, CHIPRA added Section 2111(b)(2) of the Act, which permits a state with existing authority (prior to the passage of CHIPRA) to continue Title XXI parents coverage, but only through September 30, 2013. In September 2013, this Title XIX demonstration was amended to provide State Coverage Insurance for the currently enrolled Title XXI parents for the period of October 1, 2013 through December 31, 2013. Effective January 1, 2014, the state will be expanding eligibility under its Medicaid state plan to include parents and childless adults between ages 18 and 65.

Individuals previously eligible under this demonstration who the state determines (based on an ex parte desk review) to continue to be eligible for the expanded Medicaid program will be administratively transferred to Medicaid, and the remaining individuals will be referred to the state's health insurance exchange for coverage options.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The New Mexico State Coverage Insurance (SCI) demonstration continues coverage for non-pregnant childless adults who were originally covered under the State's Title XXI Health Insurance Flexibility and Accountability (HIFA) demonstration approved in August 2002. Approximately 23,000 childless adults, ages 19 – 64 with incomes up to and including 200 percent of the FPL who are not eligible for Medicaid, are covered under the demonstration. Enrollees receive a comprehensive benefit package delivered through managed care organizations (MCOs). Premiums and co-pays are required. The demonstration is designed to provide health care coverage to uninsured individuals who are unemployed, self-employed, or employed by an employer with 50 or fewer employees. The programmatic goals of the SCI demonstration include:

- Improving access to healthcare;
- Providing coverage that is affordable;
- Promoting personal responsibility for health and healthcare; and
- Providing coordinated and integrated care through the use of medical homes.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration, including the protections for Indians pursuant to Section 5006 of the American Recovery and Reinvestment Act of 2009.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit Title XIX state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary of Health and Human Services in accordance with Section 1115 of the Social Security Act (the Act). The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will be available only for changes to the demonstration that have been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change, and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the state, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. This analysis shall include current federal share "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the

change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of the manner in which the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under Sections 1115(e) or 1115(f) of the Act are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   As part of the demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

   a. Demonstration Summary and Objectives: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of the manner in which these objectives have been met, as well as future goals of the program. If changes are requested, a narrative of the changes being requested, along with the objective of the change and desired outcomes, must be included.

   b. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas (in (c), (d), (e), (f) below), they need not be documented a second time. Consistent with federal law, CMS reserves the right to deny approval for a requested extension based on non-compliance with these STCs, including, but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein.

   c. Waiver and Expenditure Authorities: The state must provide a list, along with a programmatic description, of the waivers and expenditure authorities that are being requested in the extension.

   d. Quality: The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and state quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

e. Compliance with the Budget Neutrality Cap: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In addition, the state must provide up-to-date responses to the CMS Financial Management standard questions.

f. Draft Report with Evaluation Status and Findings: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, at any time prior to the date of expiration. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the state elects to phase out the demonstration, the state must submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 10, a phase-out plan shall not be shorter than six months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out.** If the state elects to suspend, terminate, or not renew this demonstration as described in paragraph 9, during the last 6 months of the demonstration, individuals who would not be eligible for Medicaid under the current Medicaid state plan must not be enrolled unless the demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the state in writing that the demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the

objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must continue to comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to Section 1902(a)(73) of the Act as amended by Section 5006(e) of the American Recovery and Reinvestment Act of 2009, when any program changes to the demonstration, including, but not limited to, those referenced in STC 6, are proposed by the state. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and/or renewal of this demonstration. In the event that the state conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS.

16. **FFP.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY AND ENROLLMENT

17. **Eligibility Criteria.** The demonstration-eligible populations consist entirely of persons who are not otherwise eligible for Medicaid through the state plan.

18. The New Mexico Section 1115 SCI demonstration is comprised of the following Eligibility Groups:

    a. A childless adult (Childless Adult) eligible for coverage under this demonstration is defined as a non-pregnant, childless adult, age 19 through 64 years, with income up to and including 200 percent of the FPL, who does not otherwise qualify for Medicaid under one of New Mexico's existing Medicaid eligibility categories. A childless adult can be unemployed, self-employed, or employed by a participating employer.

       An applicant must meet the following eligibility requirements for coverage under this demonstration. The applicant must:

i. Be at least 19 but no more than 64 years of age;
ii. Not be pregnant;
iii. Not have any children or dependents living in his/her home;
iv. Not be eligible for Medicaid, CHIP, or Medicare;
v. Have net family income at or below 200 percent of the FPL;
vi. Not have voluntarily dropped private health insurance coverage within 6 months prior to the date of SCI coverage. (Qualifying events such as aging off of a parent's plan and legal separation or divorce, are not considered a voluntary drop of coverage and an individual can move between the state's subsidized high risk pool and SCI coverage.);
vii. Provide verification, including documentation of U.S. citizenship or legal immigrant status and Social Security number (or proof of application for a Social Security number) in accordance with Section 1903(x) of the Act; and,
viii. Be a New Mexico resident.

b. A former-Title XXI Parent (Title XXI Parent) eligible for coverage under this demonstration is defined as the parent enrolled in the Title XXI New Mexico State Coverage Initiative demonstration (11-W-00146/6 and 21-W-00012/6) on September 30, 2013, age 19 through 64 years, with income up to and including 200 percent of the FPL, who does not otherwise qualify for Medicaid under one of New Mexico's existing Medicaid eligibility categories. The parent can be unemployed, self-employed, or employed by a participating employer.

To qualify for coverage under this demonstration, a Title XXI Parent must:

i. Be at least 19 but no more than 64 years of age;
ii. Not be pregnant;
iii. Not be eligible for Medicaid, CHIP, or Medicare;
iv. Have net family income at or below 200 percent of the FPL;
v. Not have voluntarily dropped private health insurance coverage within 6 months prior to the date of SCI coverage. (Qualifying events such as aging off of a parent's plan and legal separation or divorce, are not considered a voluntary drop of coverage and an individual can move between the State's subsidized high risk pool and SCI coverage.);
vi. Provide verification, including documentation of U.S. citizenship or legal immigrant status and Social Security number (or proof of application for a Social Security number) in accordance with Section 1903(x) of the Act;
vii. Be a New Mexico resident; and
viii. Be a recipient, under Title XXI, of SCI coverage on September 30, 2013.

19. **Enrollment Cap.** The state may impose a limit on the number of individuals who can be served under the demonstration, based upon available state funding. As of January 1, 2010, a waiting list is in place for non-employer sponsored individuals. As of November

2010, a waiting list in place for all employer-sponsored individuals. To facilitate the phase out of the demonstration in accordance with paragraph 10, enrollment will remain closed from the period of October 1, 2013 through December 31, 2013.

20. **Enrollment Period.** The state is responsible to determine and maintain the appropriate enrollment levels in order to remain under the annual budget neutrality limit/ceiling established for the demonstration. Therefore, the state will determine the timeframe for opening enrollment for individuals and new employer groups under the demonstration based upon the capacity and amount of available budgetary resources. The state will provide written notification to CMS at least 15 days before re-opening enrollment of the demonstration.

    The state must report to CMS through the quarterly and annual reports the status of enrollment, and provide a description of the enrollment management process. In addition, the state will provide CMS with Monthly Enrollment Reports as described in paragraph 34.

21. **Participating Employers.** The SCI program targets enrollment through small employer groups. Employers with 50 or fewer employees, who do not offer health insurance coverage, may participate. There is a 12-month waiting period for an employer to participate in the SCI program, if health care coverage is voluntarily dropped by the employer. Employers must maintain participation requirements based on group size.

22. **Application Processing and Enrollment Procedures.** The application and enrollment processes under the demonstration follow the SCI processes that have been in place under the State's HIFA demonstration. The Group Enrollment Center provides support to participating employers, and SCI eligibility units provide dedicated support to processing SCI applications. All applications must be screened for Medicaid eligibility before there can be consideration for SCI coverage. There is a 12-month continuous enrollment, and SCI enrollees must be recertified by the end of the 12-month eligibility period.

23. **Screening for Medicaid and/or CHIP Eligibility.** All applicants must receive a pre-screening in order to determine possible eligibility for either Medicaid or CHIP programs before an eligibility determination is performed for the SCI demonstration.

24. **Effective Date of Coverage - No Retroactive Eligibility.** Enrollees who qualify for coverage under this demonstration will not receive retroactive coverage. The beginning effective date of coverage under the SCI program begins the first day of the month following enrollment and the receipt of premium payments.

25. **Redetermination of Eligibility.** Enrollees who are eligible for coverage under this demonstration will have eligibility redetermined every 12 months. The state will send an eligibility renewal notification to the enrollee prior to the end of the enrollee's current eligibility period. Individual enrollees are notified 45 days in advance of the recertification expiration date, and employer groups are notified 60 days in advance of the recertification date. The state may suspend eligibility redeterminations during the last

three months of 2013, and allow program participants that continue to qualify to retain SCI coverage through December 31, 2013. Following this, the state will transition to Medicaid those demonstration participants who will qualify for the state's expanded Medicaid program, and assist others in obtaining Qualified Health Plan coverage through the state's health insurance exchange, starting January 1, 2014. By October 15, 2013, the state must submit for CMS review its methodology for determining which SCI participants will transition to Medicaid, which will be incorporated into the state's 2014 Transition Plan.

26. **Change in Enrollment.** An individual enrolled through a participating employer may switch to another MCO only if the employer contracts with another MCO, or if the individual changes employers and the new employer participates in the SCI program. An individual not covered through an employer may only switch to another MCO when his/her eligibility is recertified or for "good cause". An individual may also choose to terminate from an individual plan in favor of employer coverage through an SCI group plan.

27. **Disenrollment.** An enrollee in the SCI program will be disenrolled if he/she:

    a. Exceeds the income limit of 200 percent of the FPL;
    b. Becomes eligible for Medicare, Medicaid, or CHIP coverage;
    c. No longer resides in the state of New Mexico;
    d. Attains age 65;
    e. Voluntarily requests closure of his/her case; or
    f. Fails to make required premium payments.

V. BENEFITS AND COST SHARING

28. **Benefit Package.** Benefits under the SCI program are structured to be similar to basic commercial benefit packages in New Mexico. The same benefit package is offered by all participating MCOs. The benefit package is comprehensive and is described in the chart below:

Health Benefit Plan for the SCI Program	
Service Type	**Description of Coverage**
Ambulance	Limited to emergency ground transportation to the hospital Emergency Department (ED).
Behavioral Health and Substance Abuse	Outpatient office visits and substance abuse treatment, inpatient behavioral health limited to 25 days per benefit year. (Inpatient mental health services provided in a psychiatric or acute care hospital require prior authorization.)
Cardiovascular Rehabilitation	
Dialysis	
Durable Medical Equipment (DME)	Includes medical, orthotic appliances and prosthetic devices.
Emergency and Urgent Care	Includes inpatient and outpatient emergency services in or out

Services	of the service area.
Home Health Care	
Inpatient Hospital Services	Inpatient hospitalization or home care in lieu of hospitalization or a combination of both limited to 25 days per calendar year.
Laboratory	
Occupational, Physical and Speech Therapy	Covered for short-term therapies up to 2 months and may be extended for one additional 2-month period.
Outpatient Hospital/Surgery Services	Includes use of operating, delivery, recovery, and treatment rooms, equipment and supplies, anesthesia, and medications.
Physician Services	Primary care and specialist office visits, and inpatient physician services.
Prescription Drugs	Includes all generic and prescription brand name drugs included on the MCO's preferred drug list.
Preventive Services	Includes health education, immunizations, mammography screening, and cytological screenings.
Radiology	Includes CT, MRI, routine and diagnostic x-rays, EKGs, and EEGs.
Radiation Therapy and Chemotherapy	
Transplants	Some limitations including limited to 2 transplants per lifetime.
Women's Health Services	Includes GYN care, prenatal, postpartum, and delivery (included in 25-day hospital/home health care limitation).

29. **Benefit Ceilings and Modifications.** Each beneficiary is limited to a $100,000 maximum per benefit year. The state may request to adjust the $100,000 maximum per benefit year. However, the maximum per benefit year cannot be decreased more than 5 percent in a single year, and the maximum per benefit year cannot be adjusted to an amount less than $100,000. The state must notify CMS 60 days prior to any requested change in maximum per benefit year, and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the demonstration. CMS will review the state's documentation, and, if approved, will provide a written confirmation to the state within 60 days of receiving the request.

    Beneficiaries who meet the annual claims maximum are not dropped from coverage. Beneficiaries who reach the maximum benefit are disenrolled from the SCI program and may voluntarily enroll in the state's subsidized high-risk pool.

30. **Cost Sharing.** The SCI program requires co-payments for services and prescriptions, and monthly premiums to be paid by the beneficiary and the employer. Beneficiary co-payments are outlined in the table below.

SCI Program Co-Pays			
Service	**0% - 100% FPL**	**101% - 150% FPL**	**151% - 200% FPL**
Physician/Provider Visits	$0	$5	$7

Pre/Post Natal care	$0	$0	$0
Preventive Services	$0	$0	$0
Hospital Inpatient (Medical/Surgical)	$0 per admission	$25 per admission	$30 per admission
Maternity	$0 per admission	$25 per admission	$30 per admission
Hospital Outpatient Surgery	$0	$5	$7
Home Health	$0	$5	$7
Physical Therapy, Occupational Therapy, and Speech Therapy	$0	$5	$7
Diagnostics (excluding routine lab and x-ray)	$0	$0	$0
Durable Medical Equipment	$0	$5	$7
Diabetes Treatment, Equipment and Supplies	$3	$3	$3
Diabetes Management	$0	$5	$7
Emergency Services	$0	$15 per visit	$20 per visit, waived if admitted within 24 hours
Urgent Care	$0	$5	$7
Prescription Drugs – Generic/Brand Name	$3	$3	$3
Behavioral Health and Substance Abuse – Inpatient	$0	$5	$7
Behavioral Health and Substance Abuse - Outpatient	$0	$25 per admission	$30 per admission

Beneficiaries are also required to pay premiums based on a sliding scale of the enrollee's level of income. If an individual is participating in the SCI program and is unemployed or a sole proprietor, the individual must make both the beneficiary and employer premium payments. The annual cumulative cost-sharing (co-pays and premiums) maximum cannot exceed 5 percent of the family's annual gross income. SCI premium payments are outlined below:

SCI Program Premiums		
Beneficiary FPL Level	**Beneficiary Premium**	**Employer Premium**

0-100% FPL	$0	$75
101-150% FPL	$20	$75
151-200% FPL	$35	$75

VI. DELIVERY SYSTEMS

31. **Service Delivery.** The state will use the existing SCI MCOs contracted with the state. MCOs must successfully win a competitive procurement in order to participate. All services including physical care and behavioral health are provided through SCI MCO contracts. The state may request to move the delivery of the behavioral and substance abuse benefits for SCI to a single contracted entity. The state must notify CMS 60 days prior to any requested change in the delivery of behavioral and substance abuse benefits. The notification must include a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the demonstration. CMS will review the state's request and, if approved, will provide a written confirmation to the state within 60 days of receiving the request.

VII. GENERAL REPORTING REQUIREMENTS

32. **General Financial Requirements.** The state must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in Section IX. The state must submit any corrected budget and/or allotment neutrality data upon request.

33. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the state must report demonstration enrollment figures for the month just completed to the CMS Project Officer and Regional Office contact via email, using the table below. The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A under Enrollment Count, except that they are compiled on a monthly basis.

Demonstration Populations (as hard-coded in the CMS-64)	**Point In Time Enrollment** (last day of month)	**Newly Enrolled Last Month**	**Disenrolled Last Quarter**
Childless Adults			
Title XXI Parents			

34. **Bi-Monthly Calls.** CMS will schedule conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the state is considering submitting.

CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

35. **Quarterly Progress Reports.** The state must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but are not limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;

    c. Action plans for addressing any policy, administrative, or budget issues identified;

    d. Quarterly enrollment reports for demonstration eligibles, that include the member months and end of quarter, point-in-time enrollment for each demonstration population, and other statistical reports listed in Attachment A; and

    e. Evaluation activities and interim findings.

36. **Annual Report.** The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration. The state must submit the draft annual report no later than 120 days after the close of the demonstration year (DY). Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

VIII. GENERAL FINANCIAL REQUIREMENTS

37. **Quarterly Expenditure Reports for Title XIX.** The state must provide quarterly expenditure reports using Form CMS-64 to separately report total expenditures for services provided through this demonstration under Section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX of these STCs.

38. **Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** All expenditures for health care services for demonstration participants, as defined in Section IV of these STCs, are subject to the budget neutrality expenditure limit.

39. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Expenditure Limit.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

    a. **Use of Waiver Forms.** In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the state Medicaid Manual (SMM). All demonstration expenditures claimed under the authority of Title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration Project Number (11-W-00247/6) assigned by CMS.

    b. **Reporting By Date of Service.** In each quarter, demonstration expenditures (including prior period adjustments) must be totaled and reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver by demonstration year (DY). The DY for which expenditures are reported is identified using the project number extension (a 2-digit number appended to the demonstration project number). Expenditures are to be assigned to DYs on the basis of date of service. DY 1 will correspond with federal fiscal year (FFY) 2010, DY 2 with FFY 2011, and so on.

    c. **Waiver Name.** The state must identify the Forms CMS-64.9 Waiver and/or 64.9P Waiver that report demonstration population expenditures by using waiver name "SCI Adults."

    d. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

    e. **Federally Qualified Health Center Settlement Expenses.** Within 60 days of this award, the state must propose to the CMS Regional Office a methodology for identifying the portion of any Federally Qualified Health Center (FQHC) settlement expenses that should be reported as demonstration expenditures because of a linkage between settlement payments to FQHCs and use of FQHC services by demonstration participants. Once the methodology is approved by the

Regional Office, the state will report the amounts of FQHC settlement payments identified on the appropriate Forms CMS-64.9 and 64.9P Waiver.

f. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by demonstration year on Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These Section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

40. **Title XIX Administrative Costs.** Administrative costs will not be subject to the budget neutrality expenditure limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All such administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver, using waiver name "SCI Adults Admin."

41. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the Section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

42. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the demonstration. The state must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality agreement must be separately reported by quarter for each FFY on the form CMS-37.12 for both the Medical Assistance program and administrative costs. CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

43. **Extent of Title XIX FFP for the Demonstration.** Subject to CMS approval of the

source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section IX of these STCs:

a. Administrative costs, including those associated with the administration of the demonstration; and,

b. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through Section 1115(a)(2) of the Act for childless adults and Title XXI Parents, with dates of service, coinciding with the Group's eligibility, during the operation of the demonstration.

44. **Sources of Non-Federal Share.** The state certifies that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the non-federal share for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with Title XIX of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS shall review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the timeframes set by CMS.

b. The state shall provide information to CMS regarding all sources of the non-federal share of funding for any amendments that impact the financial status of the program.

c. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid or demonstration payments. This confirmation of Medicaid and demonstration payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid or the demonstration and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid or demonstration payment.

45. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

IX MONITORING BUDGET NEUTRALITY

46. **Limit on Federal Title XIX funding.** The state will be subject to annual limits on the amount of federal Title XIX funding that the state may receive for expenditures subject to the budget neutrality agreement.

47. **Risk.** The state shall be at risk for both the number of enrollees in the demonstration, as well as the per capita cost for demonstration eligibles under this budget neutrality agreement.

48. **Budget Neutrality Expenditure Limit.** The following describes how the annual budget neutrality expenditure limits are determined, consistent with Section 2111(a)(3)(C) of the Act.

    a. **Record of Budget Neutrality Expenditure Limit.** Attachment B provides a table that gives preliminary Annual Limits (defined below) for all of the approved DYs, based on information available at the time of the initial award of this demonstration. The table also provides a framework for organizing and documenting updates to the Annual Limits as new information is received, and for eventual publication of the final Annual Limit for each DY. Updated versions of Attachment B may be approved by CMS through letter correspondence, and do not require that the demonstration be amended.

    b. **Budget Neutrality Update.** Prior to April 1 of each year, the state must submit to CMS an updated budget neutrality analysis, which includes the following elements:

        i. Projected expenditures and Annual Limits for each DY through the end of the approval period;

        ii. A proposed computation of the Trend Factor (defined below) that will be used to calculate the Annual Limit for the DY immediately following, and the Annual Limit for the immediately following DY that would be determined by that Trend Factor;

        iii. A proposed updated version of Attachment B.

    The state may request technical assistance from CMS for the calculation of the Annual Limits and Trend Factors prior to its submission of the updated budget neutrality analysis. CMS will respond by either confirming the state's calculations or by working with the state to determine an accurate calculation of the Trend Factor and Annual Limit for the coming DY. CMS will ensure that the final Trend Factors for each DY are the same for all CHIPRA Medicaid childless adult waivers. The annual budget neutrality limit for each DY will be finalized by CMS by the following date, whichever is later: (1) 120 days prior to the start of the DY, or (2) two months following the date of the most recent publication of the National Health Expenditure projections occurring prior to the start of the DY."

c. **Base Year Expenditure.** The Base Year Expenditure will be equal to the total amount of FFP paid to the state for health care services or coverage provided to non-pregnant childless adults under the New Mexico Waiver (21-W-00012/6), as reported on CMS-21 and CMS-21P Waiver forms submitted by the state in the four quarters of FFY 2009. A preliminary Base Year Expenditure total appears in Attachment B. CMS will determine a final Base Year Expenditure total following CMS receipt of the Budget Neutrality Update that the state must provide by April 1, 2010.

d. **Adjustments to the Base Year Expenditure.** CMS reserves the right to adjust the Base Year Expenditure in the event that any future audit or examination shows that any of the expenditures included in the Base Year Expenditure total were not expenditures for health care services, health insurance premiums, or premium assistance for non-pregnant childless adults participating in the New Mexico Waiver (21-W-00012/6).

e. **Special Calculation for FFY 2010.** The FFY 2010 Expenditure Projection will be equal to the Base Year Expenditure increased by 3.7 percent, which is the percentage increase in the projected nominal per capita amount of National Health Expenditures for 2010 over 2009, as published by the Secretary in February 2009.

f. **Annual Limit for DY 1.** To account for the fact that this demonstration will be active for only three-quarters of FFY 2010, the Annual Limit for DY 1 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e) times 75 percent. The Annual Limit for DY 1 will be finalized at the same time that the Base Year Expenditure is finalized.

g. **Annual Limit for DY 2.** The Annual Limit for DY 2 will be equal to the FFY 2010 Expenditure Projection (as calculated under subparagraph (e)), and prior to multiplication by three quarters as indicated in subparagraph (f), increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for 2011 over 2010, as published by the Secretary in February 2010. The Annual Limit for DY 2 can be finalized once the Trend Factor for DY 2 is finalized.

h. **Annual Limit for DY 3 and Subsequent Years.** The Annual Limit for DY 3 and the DYs that follow will be equal to the prior year's Annual Limit, increased by the percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of the DY over the year preceding that year, as published by the Secretary in the February prior to the start of the DY.

i. **Calculation of the Trend Factor.** The percentage increase (if any) in the projected nominal per capita amount of National Health Expenditures for the year beginning January 1 of a DY (PERCAP2) over the preceding year (PERCAP1) (to be referred to as the Trend Factor) will be calculated to one decimal place of

precision (example: 3.7 percent) using computer spreadsheet rounding. A sample formula for this calculation in Microsoft Excel reads as follows:

"=ROUND(100*(PERCAP2-PERCAP1)/PERCAP1,1))"

49. **Budget Neutrality Expenditure Limit for the Title XXI Parents.** The following describes how the method for calculating the annual budget neutrality expenditure limit for the Title XXI Parents group, consistent with the Expenditure Authorities granting FFP for Costs Not Otherwise Matchable for this group.

    a. **"Hypothetical" Eligibility Group.** The budget neutrality of Title XXI Parents expenditures will be established by considering the Title XXI Parents to be a hypothetical group, consisting of individuals who could have been made eligible under the Medicaid state plan. This arrangement does not allow the state to access any budget neutrality "savings" from the Title XXI Parents group. A prospective per capita cap on federal financial risk is established for the Title XXI Parents group based on the costs that the population is expected to incur under the demonstration.

    b. A separate annual budget neutrality expenditure cap is calculated for expenditures for Title XXI Parents for the first quarter of federal fiscal year 2014 (October 1, 2013 through December 31, 2013). An annual estimate for the Title XXI Parents group must be calculated as a product of the number of eligible member months reported by the state under STC VII.4(d) for the demonstration population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (c) below.

    c. The trend rates and per capita cost estimates for the Title XXI Parents eligibility group (EG) is listed in the table below. The Title XXI Parents population is a "pass-through" or "hypothetical" population. Therefore, the state may not derive savings for this population. The state may not receive FFP for expenditures for Title XXI Parents in excess of the federal share of the budget neutrality limit, which will be the total computable budget neutrality limit times the FMAP for New Mexico for FY 2014.

Demonstration Period	Parents (PMPM)	Trend Rate	Total "Parents" Budget Limit
October 1, 2013 through December 31, 2013 (inclusive)	$590.32	2.5%	$29,550,920

50. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality on an annual basis. The amount of FFP that the state receives for demonstration expenditures each DY

cannot exceed the Annual Limit applicable to that DY. If, for any DY, the state receives FFP in excess of the Annual Limit, the state must return the excess funds to CMS. All expenditures above the Annual Limit applicable to each DY will be the sole responsibility of the State.

51. **Impermissible DSH, Taxes, or Donations**. The CMS reserves the right to adjust the budget neutrality expenditure limit in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality expenditure limit if any health care-related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of Section 1903(w) of the Act. Adjustments to the budget neutrality agreement will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

X. EVALUATION OF THE DEMONSTRATION

52. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after the effective date of the demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

53. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of Section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the State's request for each subsequent renewal.

54. **Final Evaluation Design and Implementation.** CMS will provide comments on the draft evaluation design within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.

55. **Final Evaluation Report**. The state must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS' comments.

56. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the Demonstration, the state shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or its contractor.

XI. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date	Deliverable
Within 30 days of the date of award	Confirmation Letter to CMS Accepting demonstration STCs
Per paragraph 52	Submit Draft Evaluation Design
Per paragraph 8	Submit demonstration Extension Application
Per paragraph 53	Submit Interim Evaluation Report
Monthly	**Deliverable**
Per paragraph 33	Monthly Enrollment Reports
Quarterly	**Deliverable**
Per paragraph 35	Quarterly Progress Reports
Per paragraph 35	Quarterly Enrollment Reports
Per paragraph 37	Quarterly Expenditure Reports
Annual	**Deliverable**
Per paragraph 36	Draft Annual Report
Per paragraph 48	National Health Expenditure Project and Revised Budget Neutrality Analysis

ATTACHMENT A
QUARTERLY REPORT FORMAT AND CONTENT

Under Section VII, paragraph 34 of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT:

Title Line One – New Mexico State Coverage Insurance (SCI) Section 1115 Demonstration
Title Line Two - Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 1 (1/1/10 – 9/30/10)
Federal Fiscal Quarter: 2/2010 (01/01/10 – 03/31/10)

Introduction
Provide information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information
Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0."

Enrollment Count
Note: Enrollment counts should be person counts, not member months.

Demonstration Populations (as hard-coded in the CMS-64)	**Current Enrollment** (last day of quarter)	**Newly Enrolled in Current Quarter**	**Disenrolled in Current Quarter**
Childless Adults			
Title XXI Parents			

Member Month Reporting

Enter the member months for the quarter.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Childless adults				
Title XXI Parents				

Update on Enrollment Management

Provide an update of the current status of open versus closed enrollment under the demonstration. This update should describe the status for each month included in the report period and any anticipated changes in the near future.

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Developments/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the state's actions to address these issues. Specifically, provide an update on the progress of implementing the corrective action plan.

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Status of Benefits and Cost Sharing

Provide update regarding any changes to benefits or cost sharing during the quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by Title any attachments along with a brief description of the information contained in the document.

State Contact(s)

Identify individuals by name, Title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B
RECORD OF BUDGET NEUTRALITY EXPENDITURE LIMIT

Approval Date of This Version: October 9, 2012

A blank preceding a percent sign (%) or following a dollar sign ($) or "Recorded On" indicates that a value is to be entered there some time in the future.

	Initial Preliminary Estimates		**Revised Preliminary Estimates**		**Final Amounts**	
	Trend Factor	**Amount**	**Trend Factor**	**Amount**	**Trend Factor**	**Amount**
Base Year Expenditure (Paragraphs 47(c) and (d))	N/A	$170,339,544 Recorded On: 12/30/2009	N/A	N/A	N/A	$170,339,544 Recorded On: 6/1/2010
FFY 2010 Expenditure Projection (Paragraph 47(e))	3.7% Recorded On: 12/30/2009	$176,642,107 Recorded On: 12/30/2009	N/A	N/A	3.7% Recorded On: 12/30/2009	$176,642,107 Recorded On: 6/1/2010
Annual Limit, DY 1 (Paragraph 47(f))	N/A	$132,481,581 Recorded On: 12/30/2009	N/A	N/A	N/A	$132,481,580 Recorded On: 6/1/2010
Annual Limit, DY 2 (Paragraphs 47(g) and (i))	4.6% Recorded On: 12/30/2009	$184,767,644 Recorded On: 12/30/2009	N/A	N/A	4.3% Recorded On: 6/1/2010	$184,237,718 Recorded On: 6/1/2010
Annual Limit, DY 3 (Paragraphs 47(h) and (i))	4.9% Recorded On: 12/30/2009	$193,821,259 Recorded On: 12/30/2009	4.5% Recorded On: 6/1/2010	$192,528,415 Recorded On: 6/1/2010	3.3% Recorded On: 8/11/2011	$190,317,563 Recorded On: 8/11/2011
Annual Limit, DY 4 (Paragraphs 47(h) and (i))	5.2% Recorded On: 12/30/2009	$202,539,893 Recorded On: 12/30/2009	4.6% Recorded On: 8/11/2011	$199,072,171 Recorded On: 8/11/2011	2.9% Recorded On: 10/9/2012	$195,836,772 Recorded On: 10/9/2012
Annual Limit, DY 5 (Paragraphs 47(h) and (i))	5.6% Recorded On: 12/30/2009	$215,318,362 Recorded On: 12/30/2009	6.4% Recorded On: 10/9/2012	$208,370,325 Recorded On: 10/9/2012	% Recorded On:	$ Recorded On:

The "Recorded On" date indicates the date in which a particular number or percentage was first incorporated (or, "recorded") into an approved version of Attachment B.